Chirurgie, 1893, 261). While his operation on the rectum is widely and favorably known, his operation on the urethra is comparatively little known and rarely employed. Incontinence of urine is so much more common than incontinence of feces that the field for the operation in the former class is much the wider. It is an operation comparatively easy of performance, lacking in any serious danger or after-effects and apparently efficient. It only needs to be more widely known in order to be more extensively employed.

A METHOD OF ANASTOMOSING THE DIVIDED VAS DEFERENS.

Dr. Gwilym G. Davis said that a couple of years ago while aiding an inexperienced assistant to do an operation for the radical cure of an inguinal hernia the vas deferens was torn. It was strongly adherent to the hernial sac and in attempting to detach it he tore it in two.

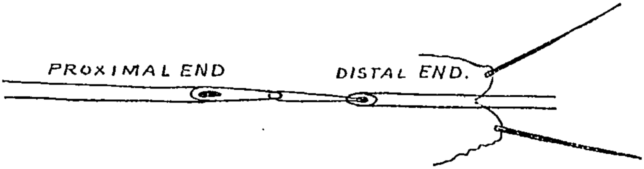
At the time the only methods known to Dr. Davis of repairing the injury were those which had been used for anastomosis of the ureter. The only method, as far as he knows, which has been devised for the anastomosis of the vas deferens is that of G. Frank Lydston (Annals of Surgery, July, 1906, p. 92, vol. xliv.) who cut the ends off square, then introduced a filament of silkworm gut on a filiform bougie through an opening in the side and sewed the two square cut ends together. The sheath of the cord was then sewn around the point of union and the bougie withdrawn in ten days.

The method adopted in the present case was a modification of that devised by Poggi for the ureter. Poggi (Archives Provinciales de Chirurgie, vol. vi, June 1, 1896, quoted by Morris Surg. of Kidney and Ureter) dilated the distal end of the ureter and drew the proximal end into it by two sutures, one on each side. Both ends of the ureter were cut off square.

Mayo Robson modified this by slitting the distal end to facilitate the entrance of the proximal end. Van Hook introduced the proximal end through a slit in the distal end on which a ligature had been placed to close its extremity. In the case now reported the proximal end of the divided vas was cut off obliquely so as to leave a moderately long pointed extremity; the distal end was cut off on a short bevel, about 45°.

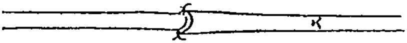
A piece of fine catgut was then threaded on two fine round sewing needles. One of these needles was passed through the tip of the proximal end then introduced into the lumen of the distal end and made to pierce the wall well beyond the opening. The second needle was then likewise introduced and brought out close to the first (Fig 1).

FIG. 1.



Traction was made on the threads and the pointed extremity of the proximal end entered the lumen of the distal end without the slightest trouble until its apex reached the point of emergence of the needles. The catgut was then tied and the apex fixed in place. Two additional fine catgut sutures were introduced, fixing the extremity of the distal end to the side of the proximal end as seen in the lower figure (Fig. 2). Healing occurred by primary union, no epididymitis nor testicular complication occurred, and as far as known the result was satisfactory.

FIG. 2.



In making the anastomosis care should be taken not to make the pointed bevel on the proximal end too long and also to introduce the needles nearly or quite their fell length before piercing the side of the tube. The object of these two precautions is to separate as far as possible the two openings in the proximal and distal ends.

It appears to be unnecessary to slit the ends as did Mayo Robson and Van Hook in the ureter, and the procedure seems both easier of performance and more sure than that of Lydston.

DR. JOHN H. GIBBON, relative to the anastomosing of the divided vas deferens, asked if Dr. Davis knew anything of the end-result in his case; whether there was testicular atrophy.

Dr. Gibbon once, very much to his distress, divided the vas in a young man, and did an invagination anastomosis, very much after the style of Murphy's anastomosis of a blood vessel. Although he was very much disappointed at the time of this accident, he got a great deal of comfort in finding out that a number of men who had done a large number of hernia operations had had a similar experience. He feels certain, however, that such an accident having once occurred, it is never likely to be done by the same operator again. In reply to this question Dr. Davis stated that the later history of the patient was not known to him.

THE USE OF CHLORIDE OF ETHYL AS A GENERAL ANÆSTHETIC.

Dr. W. E. Lee read a paper with the above title, giving a report of 5000 cases at the Pennsylvania Hospital. For this paper see page 641.

Dr. G. G. Davis asked how many of the patients which died were colored people? He thinks anæsthetics are far more fatal with this race than with white people because their color prevents the early recognition of the changes due to failure in the circulation.

Dr. John H. Gibbon said Dr. Lee had shown how superlatively statistics can lie, and he thinks that everyone reaches his own conclusions as to the safety of anæsthetics from his personal experience. For five or six years Dr. Gibbon has used chloride of ethyl absolutely for short operations, nothing but chloride of ethyl, and practically always uses it as a preliminary to ether. He has in his experience but one death to report. That was in a man who had a Ludwig's angina and an endocarditis. He was afraid to give him any general anæsthetic because of his heart condition, and therefore infiltrated the line of incision with Schleich fluid first, and then he found that the patient had a lot of exudate deep down in his neck and manipulation was very painful, so it was necessary to give him an anæsthetic. Chloride of ethyl was given, followed by ether, and Dr. Gibbon then evacuated a quantity of turbid fluid from behind the sternum. Just as this fluid was evacuated the patient ceased breathing and died on the table. No ether had been given for a number of minutes, as the patient seemed completely anæsthetized. A quick